

# "It's Just Not the Culture"

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## “It’s Just Not the Culture”: A Qualitative Study Exploring Residents’ Perceptions of the Impact of Institutional Culture on Feedback

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### ABSTRACT

*Phenomenon:* Competency-based medical education requires ongoing performance-based feedback for professional growth. In several studies, medical trainees report that the quality of faculty feedback is inadequate. Sociocultural barriers to feedback exchanges are further amplified in graduate and postgraduate medical education settings, where trainees serve as frontline providers of patient care. Factors that affect institutional feedback culture, enhance feedback seeking, acceptance, and bidirectional feedback warrant further exploration in these settings. *Approach:* Using a constructivist grounded theory approach, we sought to examine residents’ perspectives on institutional factors that affect the quality of feedback, factors that influence receptivity to feedback, and quality and impact of faculty feedback. Four focus group discussions were conducted, with two investigators present at each. One facilitated the discussion, and the other observed the interactions and took field notes. We audiotaped and transcribed the discussions, and performed a thematic analysis. Measures to ensure rigor included thick descriptions, independent coding by two investigators, and attention to reflexivity. *Findings:* We identified five key themes, dominated by resident perceptions regarding the influence of institutional feedback culture. The theme labels are taken from direct participant quotes: (a) the cultural norm lacks clear expectations and messages around feedback, (b) the prevailing culture of niceness does not facilitate honest feedback, (c) bidirectional feedback is not part of the culture, (d) faculty–resident relationships impact credibility and receptivity to feedback, and (e) there is a need to establish a culture of longitudinal professional growth. *Insights:* Institutional culture could play a key role in influencing the quality, credibility, and acceptability of feedback. A polite culture promotes a positive learning environment but can be a barrier to honest feedback. Feedback initiatives focusing solely on techniques of feedback giving may not enhance meaningful feedback. Further research on factors that promote feedback seeking, receptivity to constructive feedback, and bidirectional feedback would provide valuable insights.

### KEYWORDS

Feedback; organizational culture; politeness theory, residence training

### Introduction

The hallmark of competency-based training in medical education is the optimal combination of regular formative feedback and learning opportunities for trainees to practice skills and improve performance.<sup>1–5</sup> A developmental approach to assessment, such as the milestones-based approach recommended by the Accreditation Council for Graduate Medical Education ([www.acgme.org](http://www.acgme.org)), requires provision of ongoing meaningful feedback, preferably from multiple sources, to help clinical trainees calibrate their performance at various time points and ensure that goals are met. Yet research reports in medical education indicate that faculty feedback is vague and ineffective in changing behavior.<sup>6–8</sup> Reluctance to provide constructive feedback to avoid damaging

teacher–trainee relationships,<sup>9–13</sup> can be magnified by the fact that residents are both trainees and frontline professionals progressing toward independent practice.

Key factors that influence the process and outcomes of feedback, particularly with more advanced professional trainees, include observation of task performance, feedback provision on performance, and acceptance of the feedback by the recipient.<sup>10,11,14,15</sup> Feedback-seeking behavior is also thought to promote acceptance of feedback provided, goal setting, and performance improvement.<sup>16–18</sup> This behavior can be driven by self-motives (self-assessment, self-improvement, self-enhancement, or self-verification), personal and interpersonal factors (intentions and the characteristics of the

feedback provider, relationship between the feedback seeker and provider), and perceived positive or negative effect on self-esteem.<sup>13,16–24</sup> Finally, if feedback is perceived to be credible, it is more likely to be accepted and processed with resulting change in behavior.<sup>3,14,15,25,26</sup> Although these reports have triggered a major shift in the thinking about feedback, little is yet known about factors that trigger feedback seeking, enhance institutional feedback culture, increase consistent performance observation, and promote bidirectional feedback,<sup>27</sup> especially in graduate and postgraduate medical education settings.

Concepts from the politeness theory have been emphasized in studies by Ginsburg and colleagues, who found that faculty narrative comments on written evaluations were frequently vague and generic.<sup>28,29</sup> It is possible that faculty lack in-depth knowledge about their trainees' performance, or they perceive that their institutional culture discourages language potentially threatening to trainees' self-image, both of which could result in nonspecific and unhelpful comments.<sup>28,29</sup> The authors also described a politeness concept, "conventional indirectness," referring to the use of phrases that imply one meaning in a professional culture but are very different from their literal meanings, thus leading to teachers and learners reading between the lines. For example, descriptions such as "good," "solid," and "meets expectations" are polite on the surface but may actually indicate that the performance is borderline or below average. However, learners may not interpret these terms accurately or appreciate that their performance indeed requires improvement. How politeness affects in-person feedback conversations between teachers and trainees in medical education would be important to explore.

We wished to explore some of these issues seeking to understand residents' ideas regarding institutional and their own values about feedback and the quality of feedback from faculty. In addition, we wanted to examine why residents consistently reported in end-of-the-year surveys conducted by the graduate medical education office that feedback in our department was inadequate and unhelpful overall. This study focused on the following questions:

1. What are resident perspectives regarding institutional work climate and learning-climate-related factors that could impact the quality of feedback exchanged between faculty and residents?
2. What factors could increase the credibility of and residents' receptivity to feedback provided by faculty?
3. What are the perceptions of residents regarding the quality of feedback provided by faculty, and specifically whether they think it can be acted upon?

## Methods

Using qualitative methodology and study design,<sup>30</sup> we conducted focus group 'discussions' of residents to examine their opinions on the value and purpose of feedback in general, institutional messages about the value of and expectations for feedback conversations, facilitators and barriers to honest feedback conversations, and suggestions to enhance actionable feedback.

## Setting

The Internal Medicine Residency Program at Brigham and Women's Hospital, a teaching affiliate of Harvard Medical School, is a large, urban training program with approximately 160 residents. Inpatient teams typically consist of one or two postgraduate year (PGY) 2, 3, or 4 residents; two or three PGY1 residents; one or two attending physicians; and one or two medical students. All categorical residents (i.e., those who are not on a 1-year preliminary track) work in continuity clinics with a primary faculty preceptor throughout their residency. Preliminary residents, those on a 1-year track prior to other specialty residencies such as neurology or anesthesiology, do not work in continuity clinics but work on inpatient medicine services.

Residents are formally assessed by their supervising faculty and peers at the end of each inpatient rotation and twice a year by their continuity clinic preceptors, using milestones-based assessment forms. Faculty are also required to give verbal formative feedback to each resident at the midpoint and summative feedback at the end of each inpatient rotation and periodically in continuity clinics. On most inpatient general medicine or subspecialty rotations, faculty work with their team of three to six residents for 2 to 4 weeks. Only in continuity clinics do residents have a longitudinal one-on-one working relationship with their preceptor. Residents are exposed to a variety of faculty levels from novice to seasoned clinicians. For some of the clinician investigator faculty, their teaching commitments for an entire year might be limited to a 2-week rotation on a house staff team. Sporadic feedback workshops are offered at the institution, but there is no requirement that all teaching faculty receive formal training in feedback. There are also limited opportunities for faculty to discuss challenges and refine best practices.

## Framework and sampling

We used a constructivist grounded theory approach to explore opinions of participants.<sup>31–33</sup> In this approach, narratives of participants allow researchers to

reconstruct experiences and their meaning using an interactive process.<sup>34</sup> A purposive sampling strategy was used to recruit residents for the focus groups. Purposive sampling strategies target representative groups or groups with specific characteristics.<sup>32</sup> In this study, we sampled groups of categorical residents (on a 3- or 4-year residency track and not in the 1-year preliminary track) in our program seeking to obtain a range of opinions regarding the value, quality of feedback provided by faculty, impact on performance, and their perceptions of the departmental feedback culture. This sample was selected from a possible pool of 140 residents, the number enrolled in a 3- to 4-year Internal Medicine track. We intentionally used heterogeneous groups of PGY1, 2, and 3 residents to obtain opinions from different levels of trainees, aiming to facilitate rich interactions among the different levels of residents, given that they work closely together and learn from each other.

### Data collection

The principal data collection was through focus group discussions,<sup>33,35</sup> supplemented by investigator observations and field notes during the discussions. Focus groups were selected to enhance the richness of data through group interactions, for feasibility reasons given residents' busy clinical schedules, and to maximize the number of participants in a shorter time frame.

Participant opinions regarding the value of feedback, institutional expectations and messages around feedback, quality of feedback, and barriers to receptivity were explored. Focus group questions were semistructured to maintain the flexibility to discover unanticipated issues. Four focus group discussions were scheduled between December 2013 and February 2014; all groups consisted of PGY1, 2, and 3 residents during their scheduled ambulatory conference time for convenience. The dedicated conference time was selected because of residents' busy schedules and to maximize participation.

All prospective participants received e-mail invitations describing the purpose of the study, emphasizing that participation was voluntary and ensuring confidentiality of opinions. Verbal consent was obtained from participants, with the opportunity to opt out at any point. The study was granted exempt status by the Partners Institutional Review Board, the review board for Brigham and Women's Hospital (Protocol #2013P002270/BWH).

Focus group discussions lasted approximately 60 minutes. Two investigators, a faculty member, and a resident were present at each discussion. To minimize any power differences, discussions were led by the resident while the faculty member observed the interactions and

made field notes. The faculty investigator (SR) was neither a program director nor responsible for promotion or graduation decisions. To maximize reflexivity, focus group facilitators were trained in using prompts and probes, facilitating participant interactions and avoiding injecting their own biases into the discussions.<sup>36</sup> Postdiscussion debriefing of the research team reemphasized these principles.

The interviewer used open-ended questions as initial prompts (listed next), followed up on responses, and sought clarification or elaboration as required. Trigger questions, discussed in advance by the research team, were used to initiate conversations, responses were further probed, and further open-ended questions were posed to ensure that the content of the discussions covered the study questions. Whenever conversations spontaneously covered topics relating to the study questions, the interviewer did not interrupt. Sample triggers included the following:

- Does feedback provided by faculty facilitate performance improvement?
- What are the strengths and weaknesses of the current feedback system in our residency program?
- Can you describe challenges encountered when you give or receive feedback?
- Can you suggest strategies to improve the feedback culture in our department?

### Data analysis

We audiotaped all discussions and used a transcription service to transcribe them; no identifying information was retained in the transcripts. We used the principles of grounded theory to identify themes through analysis of participants' conversations (rather than through a priori hypotheses) and generate a theory or concept about the process of feedback.<sup>31</sup> Analysis, performed manually, occurred concurrently with and informed ongoing data collection. Trigger questions and probes were modified as appropriate for future discussions. Data collection was stopped when it appeared that no additional themes related to our study questions emerged and there was adequate information to construct a theoretical understanding of the problem being studied. Participants in our fourth focus group did not raise any new concepts about the feedback culture, and we considered data gathered as sufficient to answer our study questions. Two investigators independently reviewed and coded transcripts and established coding categories. We analyzed the data and interpreted their significance concurrently, a strategy known as "immersion and crystallization."<sup>30,37</sup> During open coding, each data unit referring to a specific issue was assigned a code consistent with participants'



terminology to minimize subjective bias. We then performed thematic analysis to identify major themes reflecting words and phrases used by participants. Ambiguities or disagreements in coding and generation of themes were resolved by consensus at research team meetings, which involved two additional investigators reviewing the analysis. Our interpretation of data was further validated by informal checking-in discussions with some of the participating residents a few weeks later.

## Results

Thirty-eight residents participated in our focus groups: 12 in Group 1, 10 in Group 2, and eight in each of Groups 3 and 4. PGY1, 2, and 3 levels of training were well represented within each group. The 38 residents were a sample of volunteers from among 140 residents on a 3- or 4-year training track.

We identified five major themes from our data analysis. Residents' discussions appeared to emphasize the feedback culture of the institution and relationships between faculty and residents, even though these were not directly probed by the investigators. The themes were as follows: (a) The cultural norm lacks clear expectations and messages around feedback, (b) the prevailing culture of niceness does not facilitate honest feedback, (c) bidirectional feedback is not part of the culture, (d) faculty–resident relationships affect credibility and receptivity to feedback, and (e) there is a need to establish a culture of longitudinal professional growth. These themes, which appeared to represent fundamental beliefs held by residents on the role of feedback in their training, are described in more detail next, with representative quotes.

The five themes related to a specific study question: the first three themes to study Question 1, Theme 4 to study Question 2, and Theme 5 to study Question 3.

### ***The cultural norm lacks clear expectations and messages around feedback***

Participants indicated that the departmental feedback culture demonstrated a disconnect between stated expectations and actual events. According to them, there was an assumption that effective feedback would occur as a result of monthly reminder e-mails, but clear expectations about the content, strategies for delivery, and action items for follow-up are deficient. In addition, time is not set aside for formal feedback conversations, nor are feedback givers and receivers guided by a suggested structure for these conversations. Those residents who had attended courses at the business school reported that expectations of feedback were much more clearly

communicated, backed up by robust training for teachers and learners on providing, soliciting, and receiving feedback respectively.

I just don't think that that's the cultural norm here. When I was in business school, there was so much feedback, and so many sessions on how to give feedback, and how to give feedback on the feedback, it became like a joke. But, it did ingrain a culture of learning to deliver feedback in specific ways, and there was an expectation that you would give it and know how to receive it. Whereas I think here, maybe that would be well-received, but maybe a person would be taking a risk. (PGY Resident 3 [R3])

Residents commented on faculty who rotate on the teaching service only for 2 to 4 weeks each year. With limited time dedicated to supervising and teaching, they were perceived as less prepared to engage in learner-centered teaching, provide timely and specific feedback or reflect on their own teaching. Participants queried whether the department explicitly communicated to faculty that the key purpose of such teaching rotations is learner growth, which requires meaningful performance-based feedback.

I've had a bunch of attendings that only attend for two weeks out of the year. The rest of the time, they're in a lab or they don't do any clinical stuff. I think they sort of forget that the purpose of this is that we're in training, it's not just to like get the work done and get out, which has felt more like the culture in those particular rotations. (R3)

### ***The prevailing culture of niceness does not facilitate honest feedback***

Residents stated that there was a “culture of niceness” within the program that they perceived as a barrier to honest feedback. They emphasized that faculty, peers, and the program leadership are “nice” and appreciative of hard work but tend to avoid constructive feedback altogether. Participants did not explicitly blame hierarchy or power relationships for this lack but related this to faculty empathy for hardworking residents, unwillingness to hurt their feelings, and a desire to maintain a nurturing work environment. However, they stated that constructive feedback is essential to enable awareness of specific areas requiring improvement, as well as concrete next steps.

People are so encouraging, you're already sweating and scared, so they want to just help you along. And I think they're being nurturing and great. And it's wonderful and I wouldn't change that, but there have been times where I've been like, am I doing OK, do you have any thoughts, and people are like yeah yeah yeah! (R2)

This “niceness” extended to peer feedback as well. Senior residents tended to omit any comments that could be construed as negative when they provided feedback to their junior peers.

The culture of feedback from us is not to give bad feedback, we don’t want to give feedback because we don’t want to hurt anyone’s feelings. It’s not doing anyone any favors. Changing the culture will be really important moving forward. (R3)

It was suggested that the departmental culture of niceness could potentially be harnessed to encourage honest feedback conversations by overt emphasis that feedback is integral for professional success and teachers and trainees should help each other grow.

It’s still in line with the “culture of niceness” to help someone succeed and reach their goals ... that’s the mentality all of us should bring to giving and accepting feedback. ... We want to see people succeed. (R2)

### ***Bidirectional feedback is not part of the culture***

Participants perceived that the departmental culture did not encourage bidirectional feedback. Residents rarely provide feedback to attending physicians; similarly, junior residents hesitate to or avoid verbal feedback to their senior peers. Senior residents who had experienced feedback from their junior trainees identified these experiences as valuable and felt that such feedback often focused on different skills than the feedback from their supervisors.

I haven’t actually gotten verbal feedback from any of my interns, but some of the written ones I’ve gone over with our program director. And I found it helpful, I wish they had done more, like how my teaching went off, stuff like that. And it’s different feedback than I would get from an attending. (R3)

I found it helpful. I wish my intern had done more. ... Interns give more feedback on the teaching, running rounds, how supportive I am, how it is working with us, the nitty-gritty. (R2)

Overall, there was a perception that faculty would not welcome constructive feedback and such requests may be just lip service. There was also some anxiety among residents whether offering “negative” feedback to attending physicians would carry some risk, though it was unclear what this risk entailed. Such perceptions resulted in near absence of bidirectional feedback.

It’s pretty awkward to give feedback to attendings. I tend to just not say anything constructive. I think they rarely ask. (R2)

When I’ve been asked to give feedback (to faculty) ... I don’t really know what to say. When asked “how do you think things are going,” I don’t know if they want specifics or just going through the motions. (R3)

Only extremely negative circumstances such as overly long rounds causing disruption of the work routine seemed to trigger residents’ feedback to attending physicians, and such conversations tended to be confrontational. One senior resident reported engaging in a collegial, honest, yet supportive dialogue with her attending, which she perceived was intended for mutual professional growth.

I gave some feedback to an attending once, because I felt like rounds were just totally horrible. I think he was a little taken aback, but I think he really appreciated it. Sort of, I don’t think he had thought so much about where we are in the year, and how rounds should be different maybe at different points. It was well received. (R2)

On rare occasions it’s been useful. It was a good back and forth, kind of thinking about how things had changed over the past week, what ways I had grown, and she invited the same feedback for her. It was an open dialogue. Six months, one occasion. (R1)

### ***Faculty–resident relationships affect credibility and receptivity to feedback***

According to participants, current feedback conversations are dominated by “good job” comments. They stated that feedback is less credible when expectations of required performance are not clear and the feedback giver has not set the stage by allowing learners to discuss their goals.

It would be really helpful to know the things expected of you ... “the ten skills you should have by the end of the year.” It helps you identify where you are weak and helps others identify where you need growth. (R1)

When interns picked one or two areas of weakness that they want to focus on, I found I was giving more feedback, more frequently, and more in-depth. It guided me in terms of how to help them. And that also makes the experience more enriching for me. (R3)

Feedback not based on firsthand observation appeared to lack credibility. When used as the basis of a feedback conversation, the comments neither provided specific information on performance nor were likely to be acceptable to residents.

I’ve been given feedback on things that weren’t observed. ... It’s confusing to me how an attending can comment on my physical exam skills if he or she has never seen me. ... I think that is fundamental to providing any sort of feedback. (R3)

Summative feedback provided solely at the end of a rotation appeared to be less well received, as opportunities are not provided for residents to change their behavior and there is no follow-up. According to participants, this could lead to a mismatch of perceptions between feedback givers and receivers, with the former ticking a box that feedback occurred and the latter perceiving that feedback never occurred.

At the end of a rotation, you're given feedback, like "this went poorly." It's awkward and difficult, you can't really do anything to change it. (R2)

Finally, feedback comments need to be actionable with conversations concluding with concrete performance improvement plans.

What's useful is a tangible strategy to improve. ... Anybody that has concrete ways of helping you get there; I've found that to be so helpful. (R1)

### ***There is a need to establish a culture of longitudinal professional growth***

Participants suggested that efforts at changing the institutional culture might include explicit encouragement of a goal-setting conversation at the start of any rotation and further emphasis on professional growth of teachers and learners alike as a foundation for meaningful feedback.

What needs to happen is a change in culture. The way to do that isn't necessarily a mandate. Whereas, if it's a culture around self-improvement or trying to identify what needs to happen—instead of saying, give feedback every day, it's establish the expectations as a team at the beginning of every rotation. Invite a meeting that first day, one on one with the interns or residents or among everybody, saying, this is what we want out of this rotation. That way, you can gear the feedback to that. (R2)

It was suggested that faculty should have an orientation on the educational mission of the institution and the culture of ongoing improvement. This orientation is essential whether the faculty are core educators, frequent, or sporadic teachers.

Attendings are being trained to be educators. They do deserve a session on how to give good feedback. I think as a whole, the concept of growth just needs to be much more ingrained in the culture. Making sure that every attending that's on service here, whether that's an attending who's on service four months a year or an attending on service for two weeks, I think they all need to be reminded that we're here for education. (R1)

Another suggestion was that the institution actively facilitate longitudinal relationships between faculty and residents. Although continuity clinics are structured with

each resident assigned to a longitudinal preceptor throughout their training, they believed that 2-week inpatient rotations do not foster relationships or facilitate adequate performance observation, accurate performance assessment, exchange of behavior influencing feedback, and bidirectional feedback.

I think in general the best feedback comes out of longitudinal relationships. Because if it's a two-week block, you just have a snippet, and although there's growth there .... Any sort of relationship that happens over time offers better opportunities for feedback. (R3)

## **Discussion**

Our study provides several insights into residents' perspectives on key factors that influence the exchange of feedback at one large residency program. These findings are depicted in Figure 1. Residents' frequent emphasis of the department's feedback culture leads us to speculate that institutional culture is central to most of the reported themes and appeared to affect residents' perceptions of the quality, credibility, and acceptability of feedback, hence its impact. The culture was described as polite or nice; ironically the politeness served as a barrier to honest feedback conversations even though it was seen to promote a positive learning environment and



**Figure 1.** Organizational culture at the heart of the process and impact of feedback. *Note.* This figure depicts organization culture at the center of an effective feedback cycle. A culture that promotes trusting relationships, and honest dialogue between teachers and learners, can enhance credibility of and receptivity to feedback provided. In addition, trusting relationships can encourage bidirectional feedback, which in turn leads to professional growth on both sides.



appreciated by most residents. Participants believed that faculty may be overprotective of residents' feelings with a tendency to omit any constructive feedback that might be perceived as criticism. The culture was also not conducive to bidirectional feedback, either from residents to faculty or from junior to senior residents. Although residents did not wish to detract from the friendly learning environment, they suggested strategies to preserve it while moving to a behavior-changing feedback culture, which promotes professional growth.

Our residents' statements about politeness being a barrier to honest feedback conversations resonate well with facets of the politeness theory. Politeness refers to a battery of social skills that ensures self-affirmation for those engaged in social interactions.<sup>38</sup> This theory, described by Brown and Levinson, is relevant to the clinical training environment where learning occurs through social interactions and team members are dependent on one another to achieve their teaching, learning, or patient care goals.<sup>39</sup> Residents are trainees as well as frontline professionals, and it is not surprising that faculty and residents wish to be "nice" to each other and avoid exchanges that could be perceived as impolite. Constructive feedback may well be viewed as a breach of the norms of expected politeness.<sup>40,41</sup> This point was raised by Ginsburg and colleagues in their research into the quality of written comments by faculty on evaluation forms.<sup>28,29</sup> It is very likely that politeness concepts impact in-person feedback conversations even more, especially with advanced professional trainees, and is not unique to written feedback or to our institution. This culture of politeness within an institution and between individuals working and learning in that system needs to be addressed openly in feedback training initiatives, especially because it was flagged as a barrier by many study participants.

Many aspects of organizational culture, which influences how its members think, feel, and act, are likely to be relevant to the process, quality, and impact of feedback conversations. Schein defined organizational culture as "a pattern of shared basic assumptions invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration."<sup>42</sup> (pp.6–7) Such assumptions are taken for granted and taught to new members as the correct way to perceive, think, and feel. The competing values framework refers to how an organizational culture balances two key dimensions that influence its effectiveness: organizational focus (internal or external) and organizational preference for structure (the balance between stability, control, flexibility and change).<sup>43</sup> It has been reported that an organizational culture that consists of a certain level of risk taking; flexible policies, and procedures; strong leadership and strict hierarchy; a high concern for new ideas and

teamwork; and a focus on growth and innovation can positively impact successful curriculum reform in medical education.<sup>44</sup> In some organizations, members tend to challenge one another openly, whereas in others, members are polite and avoid disagreeing or criticizing openly. It appears that our institutional culture falls under the latter category, at least where feedback conversations are concerned. Thus, change management involves understanding of the culture of an organization, cultural barriers to change, developing strategies to deal with potential sources of resistance, and creating a shared vision.

The process and impact of feedback relies on interpersonal interactions and relationships between feedback givers and recipients, situated within an institutional culture.<sup>45</sup> Sargeant et al. described a facilitated feedback model using the sociocultural lens that could enhance its acceptance and lead to performance improvement. They described four phases in this model: build relationships, explore reactions, explore content, and coach for performance change.<sup>46</sup> Konings et al. indicated that a participatory design, which integrates multiple perspectives from learners, teachers, and leaders, is more likely to enhance learning and the effectiveness of learning environments, and this view has implications for co-construction of bidirectional feedback.<sup>47</sup> Thus, training on techniques for delivering feedback alone, which dominates much of faculty development on this topic, is unlikely to enhance its impact on behaviors or performance or promote honest conversations and bidirectional feedback.

This study has a few limitations that may have affected our findings. Opinions of residents from a single department at a single institution limit the transferability of findings. Although the exploration yielded significant quantity of narrative data, we may not have captured fully a wide range of opinions. The focus group discussions lasted 60 minutes, and we cannot be sure that all participants had sufficient time to express opinions in detail. Our study focused on resident perspectives and did not explore opinions of faculty, which are likely to reflect additional challenges not perceived by trainees. The issue of politeness was unanticipated, and what the residents perceive to be the components of a feedback culture is unclear. Both topics warrant further exploration as a next step, particularly as they relate to the sociocultural aspects of feedback. Finally, we did not define in detail or distinguish formative and summative feedback. It is entirely possible that each of the types has its own challenges, and we cannot be sure which of the two types specific themes relate to.

### ***Implications for practice and future research***

Future research should seek to gain a better understanding of the sociocultural factors that facilitate or challenge

feedback exchanges. Such understanding could lead to strategies to address these barriers and promote the understanding that feedback is not solely about the skills of providing it but more about co-construction by both participants and related to professional goals, which would enhance acceptance, incorporation, and behavior change.

We plan to further explore perspectives of residents and faculty about the culture of politeness that was alluded to, factors influencing this culture, the various professionals who contribute to it, and how this can be harnessed to enhance meaningful feedback. Institutional leaders, faculty, and trainees will all need to be involved in designing feedback initiatives to encourage feedback seeking and promote bidirectional performance-improving conversations.<sup>48</sup> Facilitating longitudinal relationships between faculty and residents would also likely increase the credibility and acceptance of feedback.<sup>11,49</sup> Short rotations with limited direct interactions between faculty and trainees may have a deleterious effect on direct observation and feedback.<sup>50,51</sup> Faculty need to be actively encouraged to solicit feedback on their clinical and teaching performance, and residents need to be trained and persuaded that there is an institutional expectation that feedback would be bidirectional. We anticipate that attempts to encourage bidirectional feedback will prove challenging given the hierarchical nature of the clinical environment, but we hope to understand ways to harness the culture of politeness to promote honest, reflective conversations aimed at professional growth, and thus an open feedback culture.<sup>49</sup>

## Conclusion

Before implementing yet another feedback initiative, it is essential to acknowledge and explicitly address cultural, social, emotional, and interpersonal factors that impact feedback. Ultimately, residents and faculty should view feedback as a bidirectional exchange within a social culture that encourages reflective practice and ongoing professional development for both, as they work toward the common goal of excellence in patient care.

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